



Health Study Questionnaire

Please complete the attached questionnaire.

Your answers will be kept confidential.

Ask a staff person if you are not sure about any of the questions.

You can skip any questions you prefer not to answer.

You may be interrupted if a tester needs you for another test, but can continue to answer the questionnaire items after this interruption.

Thank you for completing the questionnaire.



Health Study Questionnaire

SECTION I: RESIDENCE INFORMATION

1. How many years have you lived in East Liverpool? _____ years
2. Address: (Please list the addresses of the last 3 places you have lived for more than a year)

A. Current Address:

Street address _____ From: month _____ year _____
 City _____ State ____ ZIP _____ To: Present

B. Previous (most recent) address:

Street address _____ From: month _____ year _____
 City _____ State ____ ZIP _____ To: month _____ year _____

C. Previous address:

Street address _____ From: month _____ year _____
 City _____ State ____ ZIP _____ To: month _____ year _____

D. If you have lived at more than 3 addresses for more than 1 year, please let us know and we will provide you with a supplemental residency sheet.

3. Are you on the public water supply?

- ☐ Yes
☐ No

SECTION II: SYMPTOMS

Are you experiencing any of the following symptoms?
 (Please ✓ and, IF YES, write in year started.)

	NO	YES	When did you experience it for the first time? (year)	How many times did you experience this in the LAST MONTH?
1. Problems sleeping	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
2. Problems falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
3. Waking up too often	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
4. Waking up too early	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
5. Having nightmares	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
6. Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
7. Difficulty waking up in the morning	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
8. Difficulty staying awake during the day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
9. Awakening with muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
10. Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
11. Changes in handwriting	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
12. Changes in sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
13. Changes in sense of taste	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
14. Changes in walking	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
15. Confusion or feeling lost	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
16. Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
17. Cramping in legs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
18. Dark vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
19. Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
20. Dim vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
21. Difficulty chewing	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
22. Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
23. Difficulty driving because of feeling dizzy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
24. Difficulty getting out of chairs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
25. Difficulty sitting up straight	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
26. Difficulty turning in bed	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
27. Difficulty with skilled movements	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
28. Difficulty writing	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
29. Excessive perspiration	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Are you experiencing any of the following symptoms?
 (Please ✓ and, IF YES, write in year started.)

	NO	YES	When did you experience it for the first time? (year)	How many times did you experience this in the LAST MONTH?
30. Excessive salivation	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
31. Facial expression changes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
32. Facial muscle tightness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
33. Feeling anxious	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
34. Feeling depressed	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
35. Feeling irritable	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
36. Feeling lightheaded or dizzy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
37. Fever, chills	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
38. Hand or foot tapping	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
39. Headaches at least twice a week	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
40. Joint pain or swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
41. Loss of consciousness (fainting)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
42. Loss of coordination or balance	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
43. Loss of muscle strength in arms/hand	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
44. Loss of muscle strength in legs/feet	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
45. Loss of sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
46. Lower tolerance for alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
47. Metallic taste in mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
48. Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
49. Monotonous voice	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
50. Muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
51. Muscle twitching	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
52. Muscular rigidity	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
53. Nausea not cause by something you ate	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
54. Noticeable change in personality	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
55. Numbness/tingling in fingers or feet, for more than one day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
56. Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
57. Shortness of breath on exertion	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
58. Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Are you experiencing any of the following symptoms?
(Please ✓ and, IF YES, write in **year** started.)

	NO	YES	When did you experience it for the first time? (year)	How many times did you experience this in the LAST MONTH?
59. Slowness of movement	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
60. Slurred speech	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
61. Stomach cramps / stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
62. Tremors or Shakiness (temporary)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
63. Tremors or Shakiness (long term)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
64. Trouble remembering things	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
65. Urinary or Bowel incontinence	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
66. Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
67. Wheezing or whistling in chest	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
68. Weight fluctuation	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
69. Respiratory problems on 'bad air' days	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
70. Bringing phlegm from chest into throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
71. Dizziness <u>when in the presence of gas</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
72. Headaches <u>when in the presence of gas</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
73. Dizziness <u>when in the presence of paint</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
74. Headaches <u>when in the presence of paint</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

75. When you are driving and have just passed a light, do you worry that it was red? (please ✓ one)

- ☐ Never (**skip to 76 below**) ☐ Occasionally
☐ Rarely ☐ Frequently

A. When did you experience it for the first time? (**year**) _____

B. How many times did you experience this in the LAST MONTH? _____ **times**

76. Do you consider yourself allergic or unusually sensitive to everyday chemicals like those in household cleaning supplies, paints, perfumes, soaps, garden sprays or things like that?

- ☐ Yes
☐ No (**IF NO, skip to MEDICAL HISTORY section**)
☐ Not Sure/Don't Know (**IF NOT SURE, skip to MEDICAL HISTORY section**)

77. If YES, how old were you when you first noticed this sensitivity? _____ (age)

IF you don't remember, did you have it:

- ☐ Entire life
☐ Don't remember what age, but not entire life
☐ Don't know/ Not sure

78. Was there something that happened when you were that age that first triggered this sensitivity?

- ☐ Yes
☐ No (IF NO, skip to MEDICAL HISTORY section)
☐ Not Sure/Don't' Know (IF NOT SURE, skip to MEDICAL HISTORY section)

79. IF YES, what was it? _____

SECTION III: MEDICAL HISTORY

Have you ever been diagnosed by a doctor as having any of the following illnesses or conditions?

(Please ✓ and, **IF YES**, write in the **year** when diagnosed.)

	NO	YES	Year diagnosed	Had it within the last year?		
				No	YES	
1. Acute Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	How many times in last year? _____
2. Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
3. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
4. Chest Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
5. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	How many times in last year? _____
6. Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	How many times in last year? _____
7. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
8. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	How many times in last year? _____
9. Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	

Have you ever been diagnosed by a doctor as having any of the following illnesses or conditions?

(Please ✓ and, **IF YES**, write in the **year** when diagnosed.)

	NO	YES	Year diagnosed	Had it within the last year?		
				No	YES	
10. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
11. Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
12. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	How many times in last year? _____
13. Chest pain with exertion	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
14. Heart valve disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
15. Bone or joint cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
16. Brain cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
17. Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
18. Cancer of esophagus (swallowing tube), stomach, intestines, colon, rectum, liver, pancreas, or other digestive organs	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
IF YES , which type? _____						
19. Kidney or bladder cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
20. Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
21. Lymphoma or lymph system cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
22. Lung or chest cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
23. Multiple myeloma	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
24. Male or female organ cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
IF YES , which type? _____						
25. Mouth or throat cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	

Have you ever been diagnosed by a doctor as having any of the following illnesses or conditions?

(Please ✓ and, **IF YES**, write in the **year** when diagnosed.)

	NO	YES	Year diagnosed	Had it within the last year?		
				No	YES	
26. Nasal cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
27. Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
28. Thyroid cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
29. Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
30. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
31. Other eye problems (not related to glasses or contacts)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
IF YES , which type? _____						
32. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	How many times in last year? _____
33. Psychiatric / nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
IF YES , which type? _____						
Were you given medication?	<input type="checkbox"/>	<input type="checkbox"/>	_____			
IF YES , which medication? _____						
34. Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
35. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
36. Hepatitis, jaundice or other liver disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
37. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
IF YES , which type? _____						
38. Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	How many times in last year? _____
39. Diseases of bones, joints, muscles	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	

Have you ever been diagnosed by a doctor as having any of the following illnesses or conditions?

(Please ✓ and, **IF YES**, write in the **year** when diagnosed.)

	NO	YES	Year diagnosed	Had it within the last year?		
				No	YES	
40. Kidney problems / infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
41. Bladder infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	How many times in last year? _____
42. Cold sores or mouth ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	How many times in last year? _____
43. Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
44. Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
45. Head injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
46. Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
47. Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
48. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	How many times in last year? _____
49. Sinus trouble / Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	How many times in last year? _____
50. Back or spine problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
51. Swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	How many times in last year? _____
52. Aplastic anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
53. Niemann-Pick's disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
54. Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
55. Amyotrophic Lateral Sclerosis (ALS), aka Lou Gehrig's disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
56. Huntington's chorea	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
57. Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	
58. Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	

Have you ever been diagnosed by a doctor as having any of the following illnesses or conditions?

(Please ✓ and, **IF YES**, write in the **year** when diagnosed.)

	NO	YES	Year diagnosed	Had it within the last year?	
				No	YES
59. Autoimmune Connective Tissue Disorders (Lupus, Rheumatoid arthritis)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
60. Tremor disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
61. Silicosis, aka Grinder's disease or Potter's rot	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
62. Other major illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

IF YES, which type? _____

63. Have you been hospitalized in the last 5 years? No ☐ Yes ☐ **IF YES** what year? _____

IF YES, what was the condition? _____

If you were hospitalized more than once in 5 years, please list these below:

SECTION IV: MEDICATIONS

1. Have you taken any medication in the last 24 hours (including prescription and over-the-counter)?

☐ Yes

☐ No (**IF NO**, skip to question 4)

2. What medication(s) did you take in the last 24 hrs.? _____

3. When did you first take that medication? ____/____ (month/year)

4. Have you taken the following **over-the-counter** medications? If YES, please write the name/brand.

Over-the-counter			If YES, please write name/brand	√ if taken in last month	If YES, how many do/did you take?		
	NO	YES			Per Year	Per Month	Per Day
1. Antacids or Stomach Medicine (Maalox, Mylanta, Tums, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
2. Cough Medicine	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
3. Cold Medications	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
4. Skin Medications or Creams	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
5. Headache Medicines	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
6. Sleeping Pills	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
7. Pain Medications (Aspirin, Tylenol, Advil, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
8. Iron Supplements	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
9. Vitamin Supplements with Iron	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
10. Herbal Medicine	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
11. Other:	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____

5. Have you taken the following **prescription** medications? If YES, please write the name/brand.

Prescription			If YES, please write name/brand	√ if taken in last month	If YES, how many do/did you take?		
	NO	YES			Per Year	Per Month	Per Day
1. Prescribed Antacids or Stomach Medicine	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
2. Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
3. Arthritis Medicine	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
4. Blood Pressure Medicine	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
5. Medications for Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____

Prescription	NO	YES	If YES, please write name/brand	√ if taken in last month	If YES, how many do/did you take?		
					Per Year	Per Month	Per Day
6. Heart Medicines (for heart problems or irregular heartbeat, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
7. Cholesterol Medicines (for lowering lipid, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
8. Diabetes Medicines	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
9. Eye Medications	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
10. Prescribed Headache Medicines	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
11. Muscle Relaxants	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
12. Medicine for Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
13. Medicine for Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
14. Prescribed Pain Medications	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
15. Parkinson's/Tremor Medication (L-DOPA, Sinemet, Azilect, Mirapex, Mysoline, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____
16. Other:	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____	_____

SECTION V: WORK HISTORY & BEHAVIORS

1. What is your current employment status? Please √ all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Employed full-time | <input type="checkbox"/> Employed part-time |
| <input type="checkbox"/> Unemployed | <input type="checkbox"/> Homemaker |
| <input type="checkbox"/> Full-time student | <input type="checkbox"/> Part-time student |
| <input type="checkbox"/> Retired | <input type="checkbox"/> Disabled |
| <input type="checkbox"/> Other (please specify) _____ | |

2. **If you are disabled**, please answer the following:

A. What date did you become disabled? ____ / ____ (month/year)

B. **How** did you become disabled? _____

C. Please list any jobs and the time worked **since your disability**:

<u>Position</u>	<u>Tasks</u>	<u>Duration</u> (example: 1975 to 1978)
_____	_____	_____
_____	_____	_____

3. **If not currently employed**, are you receiving: (*please √ all that apply*)

- | | |
|--|---|
| <input type="checkbox"/> Not receiving any benefits/assistance | <input type="checkbox"/> AFDC |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> General Assistance |
| <input type="checkbox"/> Disability | <input type="checkbox"/> SSI |
| <input type="checkbox"/> Other (<i>please specify</i>) _____ | |

4. Please list your employers, starting with current or most recent employer, dates of employment, and position held:

- A. _____ from _____ to _____ Position _____
- B. _____ from _____ to _____ Position _____
- C. _____ from _____ to _____ Position _____
- D. _____ from _____ to _____ Position _____
- E. _____ from _____ to _____ Position _____

5. For how many months were you employed in the past 2 years? _____

6. Approximately how many days were you sick at home in the past 2 years? _____

7. Did any of your employment involve exposure to chemicals?

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Yes | (Please describe in the table below) |
| <input type="checkbox"/> No | (Skip to question 8) |
| <input type="checkbox"/> Not Sure/Don't Know | (Skip to question 8) |

Employer / Position	Duration (Please list years)	Type of chemical?			
		<u>Solvents</u>	<u>Pesticides</u>	<u>Metals</u>	Not sure <u>which type</u>
_____	_____ to _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____ to _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____ to _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____ to _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever participated in any of the following hobbies?

NO

YES

8. Welding

☐
☐

9. Gardening

☐
☐

10. Painting

☐
☐

11. Ceramics/sculpting

☐
☐

12. Stained glass

☐
☐

13. Metal Work/Jewelry

☐
☐

14. Photo lab developing

☐
☐

15. Have you had chemical exposure at home or while doing hobbies (not during work)?

☐ Yes (IF YES, please describe below)

☐ No (IF NO, continue with question 16)

IF YES, please describe and indicate when (year): _____

16. Do you currently smoke?

- ☐ Yes **(IF YES, skip to question 19)**
☐ No

17. Have you ever smoked more than 100 cigarettes (or 5 packs) in your life?

- ☐ Yes
☐ No **(IF NO, skip to question 22)**

18. When did you stop smoking? _____/_____(month/year)**19. At what age did you begin smoking? _____****20. For how many years did you smoke? _____ Years****21. How many cigarettes per day (not packs)? _____ cigarettes****22. Does someone in your household smoke?**

- ☐ Yes
☐ No

23. Do you drink alcoholic beverages?

- ☐ Yes
☐ No **(IF NO, skip to question 31)**

24. How long have you been consuming alcoholic beverages? ____ years**25. For each type of alcohol below, please indicate **on average** how many days a week you drink and how much you drink on those days that you do:**

Type of alcohol:	Drink it?		If YES, days per week	If Yes, drinks per day
	No	Yes		
a. Beer (bottle)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
b. Wine (glass)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
c. Hard liquor (1½ oz.)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

26. Has there been a change in how your body reacts to alcohol?

☐ Yes

☐ No (IF NO, skip to question 28)

27. Can you tolerate:

☐ More

☐ Less

28. Has there has been any change in your drinking habits?

☐ Yes

☐ No (IF NO, skip to question 31)

29. In what year was the change in your drinking habits? _____

30. What was the change in your drinking habits? (please \checkmark only one)

☐ Drink more now

☐ Drink less now

☐ No longer drink

31. Please estimate the number of hours spent per day in:

	<u>Weekday</u>		<u>Weekend</u>	
<u>SPRING / SUMMER</u>	Average # of hours per day	# of hours of heavy physical exertion per day	Average # of hours per day	# of hours of heavy physical exertion per day
a. Outdoors	_____	_____	_____	_____
b. Indoors	_____	_____	_____	_____
<u>FALL / WINTER</u>	Average # of hours per day	# of hours of heavy physical exertion	Average # of hours per day	# of hours of heavy physical exertion
a. Outdoors	_____	_____	_____	_____
b. Indoors	_____	_____	_____	_____

32. In Spring / Summer, approximately how many hours per day do you **keep windows open**?
_____ hrs.

33. In Spring / Summer, approximately how many hours per day do you **use an air conditioner**? _____ hrs. (if no a/c, please enter 0)

34. In Fall / Winter, approximately how many hours per day do you **keep windows open**?
_____ hrs.

35. In Fall / Winter, approximately how many hours per day do you **use an air conditioner**?
_____ hrs. (if no a/c, please enter 0)

36. On average, how many hours per night do you sleep? _____ hours

37. In the past 12 months, have there been any major life events that have had an impact on your life (example: major illness, death of someone close)?

- ☐ Yes (please describe in the box below)
☐ No (IF NO, skip to the DIET section below)

38. Do you feel that this event(s) affected your physical health?

- ☐ Yes
☐ No

39. Do you feel that this event(s) affected your mental health?

- ☐ Yes
☐ No

SECTION VI: DIET

As some foods contain naturally-occurring trace levels of manganese or iron, we are interested in knowing approximately how much you consume of these types of food in order to estimate your total body burden of manganese and iron. For each of these foods, please indicate approximately how much you consume each week on average. Please also indicate the approximate number of servings you have had in the last month, and in the last 3 months.

Meat and Poultry	Serving size	Approx. # of servings per week	Approx. # of servings in last month	Approx. # of servings in last 3 months	✓ if you do not eat any
1. Beef, chuck, lean only, braised	3 ounces				<input type="checkbox"/>
2. Beef, tenderloin, roasted	3 ounces				<input type="checkbox"/>
3. Beef, eye of round, roasted	3 ounces				<input type="checkbox"/>
4. Pork, loin, broiled	3 ounces				<input type="checkbox"/>
5. Turkey, dark meat, roasted	3½ ounces				<input type="checkbox"/>
6. Turkey, light meat, roasted	3½ ounces				<input type="checkbox"/>
7. Chicken liver, cooked	3½ ounces				<input type="checkbox"/>
8. Chicken, leg, meat only, roasted	3½ ounces				<input type="checkbox"/>
9. Chicken, breast, roasted	3 ounces				<input type="checkbox"/>
Seafood	Serving size	Approx. # of servings per week	Approx. # of servings in last month	Approx. # of servings in last 3 months	✓ if you do not eat any
10. Tuna, fresh bluefin, cooked, dry heat	3 ounces				<input type="checkbox"/>
11. Tuna, white, canned in water	3 ounces				<input type="checkbox"/>
12. Halibut, cooked, dry heat	3 ounces				<input type="checkbox"/>
13. Oysters, breaded and fried	6 pieces				<input type="checkbox"/>
14. Crab, blue crab, cooked, moist heat	3 ounces				<input type="checkbox"/>

15. Shrimp, mixed species, cooked, moist heat	4 large				<input type="checkbox"/>
16. Clams, breaded, fried	$\frac{3}{4}$ cup				<input type="checkbox"/>
Vegetables	Serving size	Approx. # of servings per week	Approx. # of servings in last month	Approx. # of servings in last 3 months	✓ if you do not eat any
17. Spinach, cooked	$\frac{1}{2}$ cup				<input type="checkbox"/>
18. Broccoli	$\frac{1}{2}$ cup				<input type="checkbox"/>
19. Swiss chard	$\frac{1}{2}$ cup				<input type="checkbox"/>
20. Bok Choy	$\frac{1}{2}$ cup				<input type="checkbox"/>
21. Beet greens, cooked	$\frac{1}{2}$ cup				<input type="checkbox"/>
22. Turnip greens	$\frac{1}{2}$ cup				<input type="checkbox"/>
23. Green Beans	$\frac{1}{2}$ cup				<input type="checkbox"/>
24. Peas	$\frac{1}{2}$ cup				<input type="checkbox"/>
25. Potato	$\frac{1}{2}$ cup				<input type="checkbox"/>
26. Sea Vegetables	$\frac{1}{2}$ cup				<input type="checkbox"/>
Fruits	Serving size	Approx. # of servings per week	Approx. # of servings in last month	Approx. # of servings in last 3 months	✓ if you do not eat any
27. Watermelon	1/8 melon				<input type="checkbox"/>
28. Pineapple	1 cup				<input type="checkbox"/>
29. Dried Figs	5				<input type="checkbox"/>
30. Dried Apricots	5				<input type="checkbox"/>
Soy Products	Serving size	Approx. # of servings per week	Approx. # of servings in last month	Approx. # of servings in last 3 months	✓ if you do not eat any
31. Soy Beans	$\frac{1}{2}$ cup				<input type="checkbox"/>
32. Tofu	$\frac{1}{2}$ cup				<input type="checkbox"/>
33. Tempeh	$\frac{1}{2}$ cup				<input type="checkbox"/>

Grains	Serving size	Approx. # of servings per week	Approx. # of servings in last month	Approx. # of servings in last 3 months	✓ if you do not eat any
34. Wheat Pasta	1 cup				<input type="checkbox"/>
35. Brown Rice	1 cup				<input type="checkbox"/>
36. Bran Cereal	1 cup				<input type="checkbox"/>
37. Oatmeal	1 cup				<input type="checkbox"/>
Nuts, Seeds and Legumes	Serving size	Approx. # of servings per week	Approx. # of servings in last month	Approx. # of servings in last 3 months	✓ if you do not eat any
38. Almonds	¼ cup				<input type="checkbox"/>
39. Peanuts	3½ ounces				<input type="checkbox"/>
40. Sunflower Seeds	2 Tbsp				<input type="checkbox"/>
41. Pumpkin Seeds	2 Tbsp				<input type="checkbox"/>
42. Pinto Beans	½ cup				<input type="checkbox"/>
43. Navy Beans	½ cup				<input type="checkbox"/>
44. Black eyed beans	½ cup				<input type="checkbox"/>
45. Lentils	½ cup				<input type="checkbox"/>
46. Chickpeas (Garbanzo Beans)	7 ounces				<input type="checkbox"/>
Beverages	Serving size	Approx. # of servings per week	Approx. # of servings in last month	Approx. # of servings in last 3 months	✓ if you do not eat any
47. Tea	1 cup				<input type="checkbox"/>
48. Soy Milk	½ cup				<input type="checkbox"/>
49. Tomato Juice	½ cup				<input type="checkbox"/>
50. Prune Juice	½ cup				<input type="checkbox"/>

51. Do you grow your own fruits or vegetables in the soil at your residence?

☐ Yes

IF YES, what percentage of the produce you eat is home-grown? _____%

☐ No

SECTION VII: ABOUT YOU

1. What is your sex?

- ☐ Male
☐ Female

2. What is your age? _____

3. What is your date of birth? ____/____/____ (month/day/year)

4. What is your race/ethnicity?

- | | |
|--|---|
| <input type="checkbox"/> African-American | <input type="checkbox"/> Asian or Pacific Islander |
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Hispanic/Chicano/Latino | <input type="checkbox"/> Other (please specify) _____ |

5. What is your current marital status?

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Single | <input type="checkbox"/> Widowed |
| <input type="checkbox"/> Married | <input type="checkbox"/> Living with significant other |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Other (please specify) _____ |

6. How many children do you have (including adopted and stepchildren)? _____

7. How many children live in your household? _____

8. Which of the following best describes the highest level of education you have attained?

- | | |
|---|---|
| <input type="checkbox"/> Less than 9th grade | <input type="checkbox"/> Associate Degree |
| <input type="checkbox"/> 9th-12th, no diploma | <input type="checkbox"/> 4-Yr./Bachelor's Degree |
| <input type="checkbox"/> High School Diploma/G.E.D. | <input type="checkbox"/> Graduate Degree: (please circle) |
| <input type="checkbox"/> Some college, no degree | MA/MS Ph.D. MD JD |

9. What was your **best** subject in school? _____

10. On average, what grades did you get in your **best** subject? _____

11. What was your **worst** subject in school? _____

12. On average, what grades did you get in your **worst** subject? _____

13. Have you ever been diagnosed with a learning disability?

☐ Yes (**IF YES, please specify**) _____

☐ No

14. Were you ever placed in a special education or remedial class?

☐ Yes

☐ No

15. Do you have health insurance?

☐ Yes

☐ No (**IF NO, skip to question 17**)

16. What type of insurance do you have?

☐ Private insurance

☐ Medicaid

☐ Medicare

☐ SSI

☐ Other (specify) _____

Name of insurance: _____

17. Please identify your primary doctor:

Doctor's name: _____

18. How many times have you seen a doctor or nurse in the last 12 months? _____ **Times**

19. What is your current **personal annual income** (from all sources)? (*please ✓ one*)

☐ \$0-9,999

☐ \$10,000-19,999

☐ \$20,000-29,999

☐ \$30,000-39,999

☐ \$40,000-49,999

☐ \$50,000-59,999

☐ \$60,000-69,999

☐ \$70,000-79,999

☐ \$80,000-89,999

☐ \$90,000-99,999

☐ 100,000 or more

20. What is the annual **total income of your household**? (*please ✓ one*)

☐ \$0-9,999

☐ \$10,000-19,999

☐ \$20,000-29,999

☐ \$60,000-69,999

☐ \$70,000-79,999

☐ \$80,000-89,999

ID: _____

☐ \$30,000-39,999

☐ \$90,000-99,999

☐ \$40,000-49,999

☐ 100,000 or more

☐ \$50,000-59,999

21. How many persons were supported this past year by your total household income **indicated in question 19 above** (including yourself)? _____

If you would like us to know anything else about your experiences, please feel free to write a note in the space below.

Thank you very much for your time!